DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 4 1940

Registration District No. 138

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10561

Primary Registration District No. 4078

Registrar's No. 41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Norborne Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at Home 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Carroll
(c) City or town Norborne 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Callie Jacobs.
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Fem.
5. Color or race Black
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 12 (Day) 1859 (Year)

8. AGE: Years 81 V | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Carroll County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation House Work.
11. Industry or business At Home.

FATHER
12. Name Richard Caonneaut ?
13. Birthplace Africa (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rhoda Caonneaut
15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gloss McDonald
(b) Address Norborne Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 3 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Memple Cemetary
18. (a) Signature of funeral director John Deutch
(b) Address Norborne Mo.
19. (a) April 2 40 (Date received local registrar) (b) E L Earle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st
year 1940 hour 9:00 minute 22 P. M.

21. I hereby certify that I attended the deceased from March 31st (8:45 P.M.), 1940, to March 31st (9:22 P.M.) 1940
that I last saw her alive on March 31st, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial Degeneration	3-31-40
Due to Aortic Insufficiency Hypertension	
Due to Chronic Nephritis Arteriosclerosis	
Other conditions Simple Goitre (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? —
While at work? (Specify type of place) (e) Means of injury —

23. Signature Ralph E Haskell (M. D. or other) M.D.
Address Norborne Missouri Date signed 4-1-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed John G. Deitch

Licensed Embalmer No. 3654

P. O. Address Norborne Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
—2-21-40
22659

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STANDARD CERTIFICATE OF DEATH

State File No. 10561

Registration District No. 138 Primary Registration District No. 4078 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Norborne
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Callie Jacobs
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race Black | 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Oct (Month) - 12 (Day) - 1839 (Year)

8. AGE: Years	Months	Days	If less than one day
81	5	18	min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 5-2-40 (Date received local registrar) (b) B C Cole (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Ralph E Hankels (M. D. or other)
Address Norborne Mo. Date signed

SUPPLEMENTARY

S-10561 1990